Exhibit A

AFFIDAVIT OF LEIGH-ANNE LEE

Comes now the affiant, Leigh-Anne Lee, who, having first been duly sworn, states that the following statements are true in regards to Plaintiff Denis Brock:

1. All of the statements contained in this Affidavit are true and correct and made on the basis of my personal knowledge. I am an adult citizen of the State of Tennessee, over the age of 18 years, and am competent to make the statements contained in this Affidavit. I am a legal assistant with Galligan and Newman.

2. On July 3, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Saint Thomas Outpatient Neurosurgical Center, LLC at both the addresses for the agent of service of process (Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste. 301, Nashville, TN 37203-2023) and the provider's current business address (Floor 9, 4230 Harding Pike, Nashville, TN 37205-2013 as required by Tennessee Code Annotated § 29-26-121 (a).

3. I attach as Exhibit 1 a copy of the Notice letter sent to Saint Thomas Outpatient Neurosurgical Center, LLC along with the copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Outpatient Neurosurgical Center, LLC to obtain complete medical records from each other provider being sent a Notice.

4. I attach as Exhibit 2 copies of the Certificates of Mailing from the United States Postal Service, and enclosures to Saint Thomas Outpatient Neurosurgical Center, LLC.

5. On July 3, 2013, I mailed by certified mail, return receipt requested a Notice letter and

enclosures to Howell Allen Clinic A Professional Corporation at the address for the agent for service of process (Gregory B. Lanford, M.D., 2011 Murphy Ave, Ste. 301, Nashville, Tn 37203-2023) and the provider's current business address (2011 Murphy Avenue, Suite 301, Nashville, TN 37203-2023) as required by Tennessee Code Annotated § 29-26-121 (a).

6. I attach as Exhibit 3 a copy of the Notice letter sent to Howell Allen Clinic A Professional Corporation along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Howell Allen Clinic A Professional Corporation to obtain complete medical records from each other provider being sent a notice.

7. I attach as Exhibit 4 a copy of the Certificate of Mailing from the United States Postal Service, and enclosures to Howell Allen Clinic A Professional Corporation.

8. On July 3, 2013 I mailed by certified mail, return receipt requested a Notice letter and enclosures to Debra Schamberg, R.N., (Howell Allen Clinic, 2011 Murphy Ave., Suite 301, Nashville, TN 37203) as required by Tennessee Code Annotated § 29-26-121 (a).

9. I attach as Exhibit 5 a copy of the Notice letter sent to Debra Schamberg, R.N. along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Debra Schamberg, R.N. to obtain complete medical records from each other provider being sent a notice.

10. I attach as Exhibit 6 copies of the Certificates of Mailing from the United States Postal Service, and enclosures to Debra Schamberg, R.N.

11. On July 3, 2013, I mailed by certified mail, return receipt requested a Notice letter

and enclosures to John W. Culclasure, M.D. at the address listed for Dr. Culclasure on the Tennessee Department of Health website (Howell Allen Clinic, 2011 Murphy Ave., Suite 301, Nashville, TN 37203) as required by Tennessee Code Annotated § 29-26-121 (a).

12. I attach as Exhibit 7 a copy of the Notice letter sent to John W. Culclasure, M.D., along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting John W. Culclasure, M.D. to obtain complete medical records from each other provider being sent a notice.

13. I attach as Exhibit 8 copies of the Certificates of Mailing from the United States Postal Service, and enclosures to John W. Culclasure, M.D.

14. On July 3, 2013, I mailed by certified mail, return receipt requested a Notice letter and enclosures to Saint Thomas Hospital at both the address for the agent for service of process (E. Berry Holt, III, Suite 800, 102 Woodmont Blvd., Nashville, Tn 37205-2221) and the provider's current business address (4220 Harding Pike, Nashville, TN 37205-2005) as required by Tennessee Code Annotated § 29-26-121 (a).

15. I attach as Exhibit 9 a copy of the Notice letter sent Saint Thomas Hospital along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Hospital to obtain complete medical records from each other provider being sent a notice.

16. I attach as Exhibit 10 copies of the Certificates of Mailing from the United States Postal Service, and enclosures to Saint Thomas Hospital.

17. On July 3, 2013, I mailed by certified mail, return receipt requested a Notice letter and

enclosures to Saint Thomas Health Services at the address for the agent for service of process (E. Berry Holt, III, Ste. 800, 102 Woodmont Blvd., Nashville, Tn 37205-2221) and the provider's current business address (Suite 800, 102 Woodmont Blvd, Nashville, TN 37205) as required by Tennessee Code Annotated § 29-26-121 (a).

18. I attach as Exhibit 11 a copy of the Notice letter sent to Saint Thomas Health Services along with copies of the enclosures to the letter which include a list of the names and addresses of all healthcare providers who were served Notice pursuant to Tennessee Code Annotated § 29-26-121 (a) and a HIPAA compliant medical authorization permitting Saint Thomas Health Services to obtain complete medical records from each other provider being sent a notice.

19. I attach as Exhibit 12 a copy of the Certificate of Mailing from the United States Postal Service, and enclosures to Saint Thomas Health Services.

FURTHER AFFIANT SAITH NOT.

Leigh-Anne Lee

STATE OF TENNESSEE

COUNTY OF WARREN

Sworn to and subscribed before me this 19th day of September, 2013.

Notary Public

My Commission Expires: 10/29/14

CASSIDY L. CANTRELL STATE OF TENNESSEE NOTARY PUBLIC WARREN COUNTY

Exhibit 1

LAW OFFICES OF

GALLIGAN NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]-7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]-7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M. D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan · Robert W. Newman · Susan N. Marttala · John P. Partin · Benjamin R. Newman · M. Trevor Galligan

July 3, 2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#:[redacted]-7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]-7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis D. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis D. Brock	self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

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2011 Murphy Ave.
Nashville, TN 37203

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Howell Allen Clinic
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Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
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Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

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c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
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Shoppes at the Village
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Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 2

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

To pay fee, affix stamps or meter postage here.

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Gallagher & Kennedy
3940 Main St
McMinnville, TN 37110

To: St. Thomas Outpatient Neurological Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

7010 2780 0003 2206 3560

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

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OFFICIAL USE

Postage	$0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.55
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.31

McMINNVILLE TN 37110 JUL 21 2013
07/03/2013
USPS-37110

Sent To: Saint Thomas Outpatient Neurological Center, LLC
Street, Apt. No.; or PO Box No.: FL 9 4230 Harding Pike
City, State, ZIP+4: Nashville, TN 37205-2013

PS Form 3800, August 2006 — See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Outpatient Neurological Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

COMPLETE THIS SECTION ON DELIVERY

A. Signature: ☐ Agent ☐ Addressee
B. Received by (Printed Name): D. McSally — C. Date of Delivery: 7-8-13
D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3560

PS Form 3811, February 2004 — Domestic Return Receipt — 102595-02-M-1540

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

To pay fee, affix stamps or meter postage here.

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Galligan & Newman
309 W. Main Street
McMinnville, TN 37110

To: Saint Thomas Outpatient Neurological Center, LLC
c/o Gregory B. Lanford, MD
2011 Murphy Ave., Ste 301
Nashville, TN 37203-2023

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

D Fauck

7010 2780 0003 2206 3577

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com
NASHVILLE TN 37203
OFFICIAL

Postage	$0.46
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.55
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.31

MCMINNVILLE TN 0110
21 JUL 03 2013 Postmark Here
USPS 37110 07/03/2013

Sent To: Saint Thomas Outpatient Neurological Center, LLC
Street, Apt. No.; or PO Box No.: c/o Gregory B. Lanford, M.D. 2011 Murphy Ave, Ste. 301
City, State, ZIP+4: Nashville, TN 37203-2023

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Outpatient Neurological Center, LLC
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste. 301
Nashville, TN 37203-2023

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3577

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 3

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]-7255

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1838 fax

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

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- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

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Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

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Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M. D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-25-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

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Rachel Rome, M.D.
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Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
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Hermitage, TN 37076

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Debra Schamberg, R.N.
Howell Allen Clinic
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Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
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Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 4

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

To pay fee, affix stamps or meter postage here.

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Galligan & Newman
309 W. Main Street
McMinnville, TN 37110

To: Howell Allen Clinic, A Professional Corp. Check Here
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Ste. 301
Nashville, TN 37203

PS Form 3817, April 2007 PSN 7530-02-000-9065

RE: Dixon

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®
NASHVILLE TN 37203

OFFICIAL USE

Postage	$ $0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.
Restricted Delivery Fee (Endorsement Required)	$0.
Total Postage & Fees	$ $6.31

Postmark Here
MCMINNVILLE TN 21
JUL 03 2013
07/03/2013
USPS 37110

Sent To: Howell Allen Clinic, A Professional Corp
Street, Apt. No.; or PO Box No.: c/o Gregory B. Lanford, MD
City, State, ZIP+4: 2011 Murphy Ave, Suite 301
Nashville, TN 37203

PS Form 3800, August 2006 See Reverse for Instructions

7010 2780 0003 2206 3478

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Howell Allen Clinic,
A Professional Corporation
c/o Gregory B. Lanford, MD
2011 Murphy Ave, Suite 301
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature: [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name): [signature] C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

Article Number (Transfer from service label) 7010 2780 0003 2206 3478

Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

To pay fee, affix stamps or meter postage here.

From: Gilligan & Neiman
309 W. Main Street
McMinnville, TN 37110

To: Howell Allen Clinic, A Professional Corp
2011 Murphy Ave
Nashville, TN 37203

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

PE Birch

7010 2780 0003 2206 3461

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

OFFICIAL USE

Postage	$0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.35
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.11

0110
21
JUL 03 2013
Postmark Here
MCMINNVILLE TN
USPS-37110
07/03/2013

Sent To: Howell Allen Clinic, A Professional Corp
Street, Apt. No.; or PO Box No.: 2011 Murphy Ave, Ste 301
City, State, ZIP+4: Nashville, TN 37203

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Howell Allen Clinic
A Professional Corporation
2011 Murphy Ave, Ste 301
Nashville, TN 37110

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3461

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit S

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]-7255

Dear Nurse Schamberg:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
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Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
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Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 6

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

To pay fee, affix stamps or meter postage here.

From: Galligan + Newman
309 W. Main Street
McMinnville, TN 37110

To: Debra Schamberg, RN
Howell Allen Clinic
2011 Murphy Ave, Suite 301
Nashville, TN 37203

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

7010 2780 0003 2206 3553

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)
For delivery information visit our website at www.usps.com®
NASHVILLE TN 37203
OFFICIAL USE

Postage	$0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.55
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.31

McMINNVILLE TN 21 Postmark JUL 08 2013
USPS 07/03/2013

Sent To: Debra Schamberg, RN
Street, Apt. No.; or PO Box No.: Howell Allen Clinic
City, State, ZIP+4: 2011 Murphy Ave, Suite 301
Nashville, TN 37203

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

Article Addressed to:
Debra Schamberg, RN
Howell Allen Clinic
2011 Murphy Ave, Suite 301
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☑ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3553

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 7

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan   Robert W. Newman   Susan N. Marttala   John P. Partin   Benjamin R. Newman   M. Trevor Galligan

July 3, 2013

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#[redacted]7255

Dear Dr. Culclasure:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

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- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

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Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-25-13
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Denis S. Brock	Self

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Baptist Women's Pavillion
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Nashville, TN 37203

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2011 Murphy Avenue, Suite 301
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Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
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Michael O'Neal
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Rachel Rome, M.D.
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4230 Harding Road, Suite 901
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5651 Frist Boulevard, Suite 712
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Rachel Rome, M.D.
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c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
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Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 8

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

To pay fee, affix stamps or meter postage here.

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may not be used for domestic and international mail.

From: Gilliland & Neuman
309 W. Main Street
McMinnville, TN 37110

To: John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave Ste 381
Nashville, TN 37203

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

RE Docket

7010 2780 0003 2206 3454

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®
NASHVILLE TN 37203

OFFICIAL USE

Postage	$ $0.66	0110
Certified Fee	$3.10	21
Return Receipt Fee (Endorsement Required)	$2.[illegible]	Postmark Here
Restricted Delivery Fee (Endorsement Required)	$0.00	JUL 03 2013
Total Postage & Fees	$ $6.3[illegible]	07/03/2013

McMINNVILLE TN 37110

Sent To: John Culclasure, M.D.
Street, Apt. No.; or PO Box No.: Howell Allen Clinic, 2011 Murphy Ave, Suite 381
City, State, ZIP+4: Nashville, TN 37203

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave
Suite 381
Nashville, TN 37203

COMPLETE THIS SECTION ON DELIVERY

A. Signature: [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name): [illegible] C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3454

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

Exhibit 9

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#[redacted]7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

Enclosed herein is a list of the names and addresses of all providers being sent a notice. Also enclosed are HIPAA compliant medical authorizations permitting you to obtain complete medical records from each other provider being sent a notice.

Please forward this correspondence and enclosures to your professional liability insurance carrier and/or your legal counsel. Please ask your representative (either a representative from your professional liability insurance carrier or your legal counsel) to contact me.

Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 office 931.473.1896 fax www.galligannewmanlaw.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]-7255

1. I authorize Patricia Beckham, pharmacist, John Culclaure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

2. The type and amount of information to be used or disclosed is as follows:
Health information covering treatment from June 1, 2012 to present.

- ☐ Abstract (includes H&P, Progress Notes, Procedure Notes, Procedure Reports, etc.)
- ☐ Copy of Medical Records only
- ☑ Copy of Complete Records (Medical & Financial)
- ☐ History and Physical (H&P)
- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 10

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

From: Gilligan + Newman
209 W. Main St
McMinnville, TN 37110

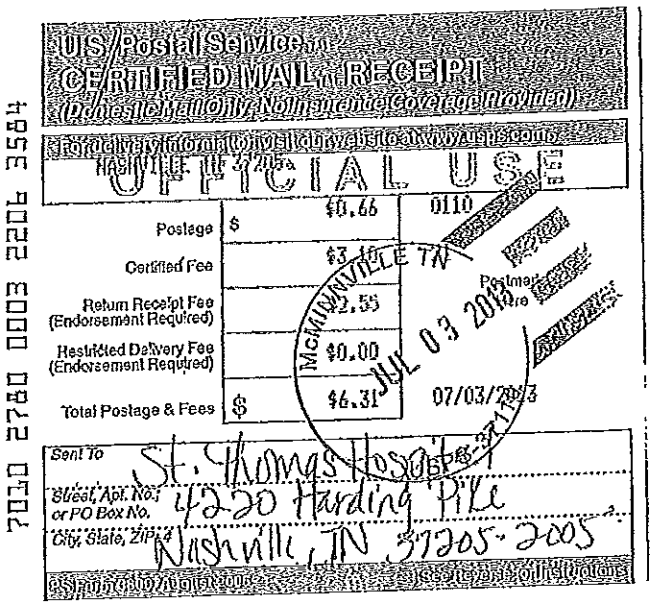
To: St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

To pay fee, affix stamps or meter postage here.

Postmark Here

Re: D. Buer

PS Form 3817, April 2007 PSN 7530-02-000-9065



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) [illegible] C. Date of Delivery 07/08/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3584

S Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

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From: Gilligan & Neuman
209 W. Main St.
McMinnville, TN 37110

To: St. Thomas Hospital
c/o E. Berry Holt, III.
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

R. D. Buck

7010 2780 0003 2204 3567

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®
NASHVILLE TN 37205
OFFICIAL USE

Postage	$0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.5
Restricted Delivery Fee (Endorsement Required)	$0.0
Total Postage & Fees	$6.31

NASHVILLE TN JUL 03 2013 USPS-37110

Postmark Here

07/03/2013

Sent To: St. Thomas Hospital
Street, Apt. No.; or PO Box No.: c/o E. Berry Holt, III. Suite 800 102 Woodmont Blvd.
City, State, ZIP+4: Nashville, TN 37205-2221

PS Form 3800, August 2006 See Reverse for Instructions

Exhibit 11

LAW OFFICES OF

GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#[redacted]-7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

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Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]-7255

1. I authorize Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M. D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

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- ☑ Copy of Complete Records (Medical & Financial)
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- ☐ Consultation
- ☐ Summary
- ☐ Discharge Summary (DS)
- ☐ Operative/Procedure Report(OP)
- ☐ Pathology Report
- ☐ Laboratory Report

Other: _____

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Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-25-13
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Denis S. Brock	self

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2011 Murphy Ave.
Nashville, TN 37203

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Howell Allen Clinic
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2011 Murphy Avenue, Suite 301
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Howell Allen Clinic, A Professional Corporation
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2011 Murphy Avenue, Suite 301
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4065 Rotterdam Pass
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Vanderbilt University Medical Center
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Rachel Rome, M.D.
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4230 Harding Road, Suite 901
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Rachel Rome, M.D.
353 New Shackle Island Road
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Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
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Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
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FL 9
4230 Harding Pike
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Saint Thomas Outpatient Neurosurgical Center, LLC
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2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

LAW OFFICES OF
GALLIGAN & NEWMAN

Michael D. Galligan Robert W. Newman Susan N. Marttala John P. Partin Benjamin R. Newman M. Trevor Galligan

July 3, 2013

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205
VIA CERTIFIED MAIL

RE: DENIS BROCK
DOB: 6/19/1947
SS#: [redacted]7255

Dear Sirs:

Pursuant to Tenn. Code Ann. §29-26-121, please be advised that I am the attorney representing DENIS BROCK and I am the authorized agent of Mrs. Brock. Through me and my firm, Mr. Brock is asserting a potential claim for medical malpractice against you. This claim arises out of care provided to Denis Brock for an out patient procedure performed at Saint Thomas Outpatient Neurosurgical Center, LLC, on July 23, 2012, wherein Mrs. Brock was injected with methylprednisolone acetate.

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Sincerely,

GALLIGAN & NEWMAN

Michael D. Galligan

309 West Main Street McMinnville, TN 37110 931.473.8405 fax 931.473.1868 www.galliganandnewman.com

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: Denis Brock DOB: June 19, 1947 Social Security Number: [redacted]7255

1. I authorize Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M. D. to Disclose my health information to : Patricia Beckham, pharmacist, John Culclasure, M.D., Howell Allen Clinic, Martin S. Kelvas, pharmacist, Michael O'Neal, pharmacist, Rachel Rome, M.D., Saint Thomas Outpatient Neurosurgical Center, Debra Schamberg, R.N., St. Thomas Hospital, Saint Thomas Health Services, and/or Scott C. Standard, M.D. The purpose(s) for the use or disclosure is as follows: litigation.

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Other: _____

3. I understand that my health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for drug and alcohol abuse.

4. I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that my revocation will not apply to the extent that the above named provider has taken action in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire in six months.

5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. The doctor or hospital may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this authorization. I understand that if I authorize the above named provider to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations. If I have any questions about disclosure of my health information I can contact the provider listed above.

Signature of Patient/Plan Member/Guardian/Patient/Plan Member Representative:	Date:
Denis S. Brock	8-27-13
Print Name of Patient/Plan Member's Representative:	Relationship to Patient/Plan Member:
Denis S. Brock	Self

OTHER PROVIDERS RECEIVING THIS NOTICE RE: DENIS BROCK

Patricia Beckham
Baptist Women's Pavillion
2011 Murphy Ave.
Nashville, TN 37203

John Culclasure, M.D.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Howell Allen Clinic, A Professional Corporation
c/o Gregory B. Lanford, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Martin S. Kelvas, Pharmacist
4065 Rotterdam Pass
Hampton, GA 30228

Martin S. Kelvas, Pharmacist
St. Thomas Hospital
P. O. Box 380
Nashville, TN 37202

Michael O'Neal
Vanderbilt University Medical Center
1211 MCD/VUH B-101
Nashville, TN 37232

Rachel Rome, M.D.
c/o St. Thomas Outpatient Neurosurgical Center
4230 Harding Road, Suite 901
Nashville, TN 37205

Rachel Rome, M.D.
353 New Shackle Island Road
Hendersonville, TN 37075

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Summit Medical Center
5651 Frist Boulevard, Suite 712
Hermitage, TN 37076

Rachel Rome, M.D.
Center for Spine, Joint and Neuromuscular Rehabilitation
Shoppes at the Village
833 Memorial Blvd., Suite E
Murfreesboro, TN 37129

Debra Schamberg, R.N.
Howell Allen Clinic
2011 Murphy Ave., Suite 301
Nashville, TN 3703

Saint Thomas Outpatient Neurosurgical Center, LLC
FL 9
4230 Harding Pike
Nashville, TN 37205-2013

Saint Thomas Outpatient Neurosurgical Center, LLC
c/o Gregory B. Lanford, M.D.
2011 Murphy Ave, Ste 301
Nashville, TN 37203-2023

St. Thomas Hospital
4220 Harding Pike
Nashville, TN 37205-2005

St. Thomas Hospital
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Saint Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Scott C. Standard, M.D.
2011 Murphy Avenue, Suite 301
Nashville, TN 37203

Exhibit 12

UNITED STATES POSTAL SERVICE®

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This certificate is not for domestic or international mail.

To pay fee, affix stamps or meter postage here.

From: Gallligan & Newman
309 W. Main Street
McMinnville, TN 37110

To: St. Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

RE: Black

U.S. Postal Service™
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com®

OFFICIAL USE

Postage	$0.66
Certified Fee	$3.10
Return Receipt Fee (Endorsement Required)	$2.21
Restricted Delivery Fee (Endorsement Required)	$0.00
Total Postage & Fees	$6.31

Postmark Here: MCMINNVILLE TN JUL 03 2013 07/03/2013

Sent To: Saint Thomas Health Services
c/o E. Berry Holt, III
Street, Apt. No.; or PO Box No.: Suite 800
102 Woodmont Blvd.
City, State, ZIP+4: Nashville, TN 37205-2221

PS Form 3800, August 2006 See Reverse for Instructions

7010 2780 0003 2206 3614

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
Saint Thomas Health Services
c/o E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☑ Agent ☐ Addressee

B. Received by (Printed Name): Crisdenbur — C. Date of Delivery: 7/8/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☑ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3614

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

UNITED STATES POSTAL SERVICE

Certificate Of Mailing

This Certificate of Mailing provides evidence that mail has been presented to USPS® for mailing. This form may be used for domestic and international mail.

To pay fee, affix stamps or meter postage here.

From: Gallligan + Newman
309 W. Main Street
McMinnville, TN 37110

To: St. Thomas Health Services
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205

Postmark Here

PS Form 3817, April 2007 PSN 7530-02-000-9065

7010 2780 0003 2206 3407

U.S. Postal Service
CERTIFIED MAIL™ RECEIPT
(Domestic Mail Only; No Insurance Coverage Provided)

For delivery information visit our website at www.usps.com

OFFICIAL USE

Postage	$ $0.66	0110
Certified Fee	$3.10	21
Return Receipt Fee (Endorsement Required)	$2.	Postmark Here
Restricted Delivery Fee (Endorsement Required)	$0.00	JUL 08 2013
Total Postage & Fees	$ $6.31	07/03/2013

MCMINNVILLE TN 37110

Sent To: St. Thomas Health Services
Street, Apt. No.; or PO Box No.: Suite 800 102 Woodmont Blvd.
City, State, ZIP+4: Nashville, TN 37205

PS Form 3800, August 2006 See Reverse for Instructions

SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:
St. Thomas Hospital
C/O E. Berry Holt, III
Suite 800
102 Woodmont Blvd.
Nashville, TN 37205-2221

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] ☐ Agent ☐ Addressee

B. Received by (Printed Name) C Rodenburg
C. Date of Delivery 7/8/13

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☐ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7010 2780 0003 2206 3591

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540